FRAMEWORK FOR ANNUAL REPORT OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by HCFA quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: **New Hampshire**

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name (s) NH Healthy Kids

SCHIP Program Type ____ Medicaid SCHIP Expansion Only
____ Separate SCHIP Program Only
__x__ Combination of the above

Reporting Period Federal Fiscal Year 2000 (10/1/99-9/30/00)

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Submission Date Jan. 1st 2001

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program=s changes and progress during Federal fiscal year 2000 (September 30, 1999 to October 1, 2000).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 1999 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 1999, please enter >NC= for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

1. Program eligibility

NC

2. Enrollment process

NC

3. Presumptive eligibility

NC

4. Continuous eligibility

NC

5. Outreach/marketing campaigns

NC

6. Eligibility determination process

NC

7. Eligibility redetermination process

NC

8. Benefit structure

NC

9. Cost-sharing policies

NC

10. Crowd-out policies

NC

11. Delivery system

NC

12. Coordination with other programs (especially private insurance and Medicaid)

NC

13. Screen and enroll process

NC

14. Application

NC

15. Other

1.2 Please report how much progress has been made during FFY 2000 in reducing the number

of uncovered, low-income children.

1. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2000. Describe the data source and method used to derive this information.

   The estimated baseline number of uncovered low-income children is 26,000. Of those 16,576 are eligible for either Medicaid or the SCHIP program (Healthy Kids Gold and Healthy Kids Silver, respectively) and of those only 4,800 children are eligible for the Silver program. As of September 30, 2000 the State has enrolled 2381 in the Healthy Kids Silver $20 program and 653 in the Healthy Kids Silver $40 program. In addition 377 infants have been enrolled in the Healthy Kids Gold (CHIP Medicaid expansion).

   The total number of children enrolled to date in the New Hampshire's Children's Health Insurance Program- Healthy Kids Gold and Silver as of September 30, 2000, was nearly 10,000. Thus the proportion of all children who are uninsured has been reduced by 39%. The proportion of uninsured children who are eligible for one of the subsidized programs has been reduced by 47%.

   The data source of the number of uninsured children in New Hampshire is a random, household telephone survey of 12,000 households in New Hampshire conducted by the NH Department of Health and Human Service's Office of Planning and Research under the direction of Steve Norton, Senior Analyst, formerly of the Urban Institute. The data source of enrolled children is actual enrollment numbers from the NH Healthy Kids Corporation, our administrator of the Healthy Kids Silver, (stand alone), component of the NH CHIP program and the Medicaid Administration Bureau.

2. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

   As of September 30 2000, 6842 in the Healthy Kids Gold (formerly Medicaid) program. The data source is actual enrollment numbers from the state's eligibility system, New Heights.

3. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

   __x__ No, skip to 1.3

   ____ Yes, what is the new baseline?

   What are the data source(s) and methodology used to make this estimate?

   What was the justification for adopting a different methodology?

   What is the State=s assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FFY 2000 toward achieving your State=s strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State=s strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1:	List your State=s strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2:	List the performance goals for each strategic objective.
Column 3:	For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter ANC@ (for no change) in column 3*.

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Increase the number of low-income children who are insured	Decrease the proportion of children 1-19 years of age, ≤ 300% FPL who are uninsured by 25% in year one, 35% in year two, 45% in year three and 50% by year four.	Data Sources: NH Household Insurance Survey (1999), NH MMIS and NH Healthy Kids Corporation. Methodology: Baseline=random household survey. Enrollment #'s =counting all children ever enrolled. Progress Summary: As of September 30, 2000, program has reduced percentage of uninsured children by 39%.
OBJECTIVES RELATED TO SCHIP ENROLLMENT		
Maximize enrollment in Healthy Kids Gold and Silver.	Increase the number of locations where individuals can get applications and receive assistance in completing applications. Increase the number of entities participating in the outreach program. Increase the percentage of applications that are complete.	Data Sources: Internal outreach data and data from the NH Healthy Kids Corp Methodology: Number of community based agencies participating in outreach program. Number of applications that are complete upon arrival to the NHHK office. Consumer satisfaction survey. Progress Summary: We have over 3,228 community partners participating in outreach activities. The partners include principals, school nurses, superintendents, childcare centers, community health centers, public health agencies e.g. WIC, hospitals, human service agencies, and Headstart programs. Our data indicate that the completeness of applications upon receipt has dropped from one-half to one-third of applications being complete upon receipt. Including a detailed checklist in the application itself is one way the state will

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
	Decrease the amount of follow up required to complete applications. Ensure that at least 75% of consumers are satisfied with the application process.	look to alleviate this problem. A new customer service database to be implemented in November will provide Healthy Kids the ability to track what information is most often missing. Few applications require more than one follow-up to obtain all documentation needed to determine eligibility. A 1999 survey of Healthy Kids consumers indicates that well over 90% of consumers are satisfied with the application process including approving of our outreach materials. The mail in unit has been a huge success with completed enrollment occurring from the mail in unit over entry via the local health and human services' district offices.
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
Maximize coordination with the Medicaid program (now named Healthy Kids Gold).	Increase enrollment in Healthy Kids Gold by 10% in the first year of operations. Establish a seamless program with integrated staff and administration	Data Sources: NH MMIS Methodology : Number of new children enrolled in the Medicaid (non-CHIP) program. Progress Summary: The Department in partnership with the NH Healthy Kids Corporation designed and implemented a comprehensive, statewide outreach and marketing campaign for both the children's health insurance programs under the Title XIX (Medicaid) and Title XXI (CHIP) programs. This partnership continues and will continue through State Fiscal Year 2001 with some additions to the outreach menu including the use of advertisement space on public vehicles such as the bus service in Concord. In addition a full time CHIP coordinator, Kate Frey, has been hired effective September 12, 2000. The creation of this position strengthens the department's infrastructure. Ms. Frey reports to the Director of the Office of Community and Public Health who continues to serve as the State CHIP Administrator. The next steps to further this process is to increase the number of state eligibility staff at the mail in unit so that all Gold applications can be completely processed on sight prior to being sent out to

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
		the district offices for maintenance. Our efforts to date have been successful in that from January 1, 1999 to September 30, 2000 the number of newly enrolled children in the poverty level Medicaid program has increased by 6,841. The goal of increasing Medicaid enrollment by 10% has been met and surpassed by 37%.
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
		Data Sources: Methodology: Progress Summary:
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
Improve the health status of children in NH with a focus on preventive and primary care.	Match or exceed the current statewide avg. % of children under two who receive basic immunization series. Match or exceed the current statewide avg. % of 13 year olds who receive basic immunization	Data Sources: Encounter data from Medicaid fiscal agent and health insurance underwriter. Methodology: Comparison of immunization rates with statewide average % = 80%. Comparison of well-child data from Maternal and Child Health and commercial insurers. Progress Summary: As of September 30, 1999 the State has created the QCHIP (Quality in Children's Health Insurance) workgroup to address the overall quality

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
	series. Match or exceed the current statewide avg. % of 3,4,5 and 6 year olds who have at least one well-child visit during the year. Match or exceed the current statewide avg. % of 12-18 year olds who have at least one well-child visit during the year.	improvement and quality assurance components of the CHIP program. The State also chose to include Medicaid in the analysis for encounter data. At the present time, the Institute of Child Health Policy under the direction of Dr. Betsy Shenkman is in the process of analyzing the data from all 3 programs. We estimate having the data available for review by the QCHIP workgroup and production of a report in Spring 2001.

OTHER OBJECTIVES		
		Data Sources: Methodology: Progress Summary:

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

NC

1.5 Discuss your State=s progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

The Office of Planning and Research of the NH Department of Health and Human Services will conduct a second Household Insurance Survey in 2001. This survey will result current data on the number of uninsured children in the state. One improvement from the 1999 study, which was strictly a telephone interview, will be sampling of households who do not have phones. The data will be available in the 4th quarter of 2001.

Healthy Kids Corporation will be contracting with the Institute on Child Health Policy at the University of Florida to conduct studies of health care usage and family satisfaction. All studies will compare the Medicaid, Medicaid Managed Care and Title XXI programs. Telephone interviews with new enrollees, established enrollees and disenrollees will be conducted in early 2001. These studies help us understand the relationship between premiums, affordability, disenrollment for non-payment, cost-sharing and utilization.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program=s performance. Please list attachments here.

Healthy Kids Corporation in coordination with the NH Department of Health and Human Service's Office of Community and Public Health designed a survey to be conducted with presumptive eligibility sites in order to understand how to improve the P.E. process and increase the number of presumptive enrollments. One on one interviews were conducted with presumptive eligibility sites.
Please see attached survey.

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

1. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

   N/A

2. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2000 (10/1/99 -9/30/00)?

   Number of adults_____
   Number of children_____

   N/A

3. How do you monitor cost-effectiveness of family coverage?

   N/A

2.2 Employer-sponsored insurance buy-in:

1. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

   N/A

2. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?

   N/A

   Number of adults_____
   Number of children_____

2.3 Crowd-out:

1. How do you define crowd-out in your SCHIP program?

   Crowd out it defined as the substitution of public coverage for private coverage. The policy instituted in New Hampshire to mitigate crowd out is to require a child to have been uninsured for 6 months before becoming eligible for Healthy Kids Silver, New Hampshire's SCHIP program.

2. How do you monitor and measure whether crowd-out is occurring?

   We monitor crowd out by collecting information of current and past insurance coverage on every applicant.

3. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

   Because New Hampshire requires children to be uninsured for six months unless good cause applies, there is little evidence of crowd-out. To date there have been only 3 families who elected to drop private insurance, wait out the 6 month period and enroll in the Healthy Kids program.

4. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

   NH has just the one policy.

2.4 Outreach:

1. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

   Historically, the most effective method of reaching families has been to distribute information through the schools. Healthy Kids Corporation has been covering kids since 1995 without direct government subsidies until the Title XXI plan was implemented in January 1999. Throughout these years, about one-third of families indicate they learned about the program through their child's school.

   The focus of our strategy is to work with organizations that directly serve families and children. What has been most effective in this strategic is the use of Outreach Coordinators in the field who develop relationships with community partners and provide outreach support through training and promotional materials.

   We see a growing number of referrals through word-of-mouth. We believe that providing fast, fair, friendly customer service to families is essential in generating the kind of family satisfaction that prompts friends, family and neighbors to encourage others to enroll.

   We measure the effectiveness of our outreach campaigns by tracking a referral source on all families that inquire and apply. These statistics can be compiled and analyzed through database queries. We also include questions regarding outreach methods and messages in periodic surveys of enrollees, disenrollees and prospective enrollees.

2. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

   To truly determine your effectiveness in reaching specific populations, you must have information regarding the insurance status of those populations. Overall, our enrollee surveys have shown that we have a higher proportional number of minority enrollees than appear in the general population based on old census data. However, when 2000 census data is released, there will be reason to review this statistic.

   New Hampshire conducted a Household Insurance Survey of 12,000 families in September 1999. We are in the process of using that data to determine how effective we have been enrolling uninsured children based geography, age and income. Once this analysis is done, we will be able to learn from those areas where enrollee penetration is high and increase outreach efforts in areas where enrollee penetration is low. When this information is available, we will determine how best to target specific constituencies where the need appears to be the greatest.

3. Which methods best reached which populations? How have you measured effectiveness?

   The first two years of outreach have been dedicated to broad-based outreach with little activity focused specifically on any one group. We are currently focusing on better understanding three

constituencies that are likely to require targeted outreach: minorities and immigrants, adolescents and rural residents. As yet we have not implemented specific and unique outreach strategies to target these groups, with the exception of raising awareness about the groups and working through community partners who serve them.

2.5 Retention:

1. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

   Re-determination is a simplified mail-in process. Families must complete and sign a new application and submit new income and deduction verifications, as well as any documentation for other changes such as address change or the age verification for a new child. For S-CHIP, families receive three contacts – letter, phone call, letter – to encourage them to renew. Special attention has been made to making the process and letters easy to understand. The effectiveness of the S-CHIP process is being reviewed to determine if resources exist to implement a similar strategy for Medical renewal. Currently Medicaid families receive a single letter notifying them of the need to renew. The actual renewal process is the same as S-CHIP, although Medicaid is case-managed by State Case Technicians and S-CHIP is managed by the Healthy Kids Corporation Customer Service Staff.

2. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

__x__ Follow-up by caseworkers/outreach workers
__x__ Renewal reminder notices to all families
____ Targeted mailing to selected populations, specify population _____
____ Information campaigns
___ Simplification of re-enrollment process, please describe _____
__x__ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe_____
____ Other, please explain_____

3. Are the same measures being used in Medicaid as well? If not, please describe the differences

   See 2.5.1

4. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

   Multiple and personalized contacts to encourage renewal.

5. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

   For S-CHIP, we capture the reason for the disenrollment based on state eligibility information or parent declaration. In FFY 2000, 65% of children who were disenrolled continued to have coverage through Medicaid or private insurance. The actual number of children who continue to be insured may be higher since some families request disenrollment through a letter or message without stating a reason.

2.6 Coordination between SCHIP and Medicaid:

1. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

   There is a common application and redetermination procedure. The same verification requirements are used for both programs during application and renewal. There is no requirement for face-to-face interviews. As noted in 2.5.1, the difference is that redetermination for Medicaid includes a single letter with no follow-up. Three attempts are made to contact S-CHIP families.

2. Explain how children are transferred between Medicaid and SCHIP when a child=s eligibility status changes.

   State Case Technicians are co-located at the Healthy Kids Corporation offices. Eligibility is determined through a single State system that qualifies a child for Medicaid or S-CHIP. If Medicaid eligible, the case opens. If S-CHIP eligible, the case pends awaiting enrollment (e.g. premium payment and selection of PCP). The referral to enroll is transmitted to New Hampshire Healthy Kids through a daily electronic data interface. The interface also transmits changes in status or family information or instructs Healthy Kids to disenroll S-CHIP children. Likewise, Healthy Kids uses the electronic data interface to inform the State eligibility system when a child has been enrolled (then the case opens) or if a child has been disenrolled. Data sent to the State by Healthy Kids Corporation is automatically processed by the eligibility system.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

   Medicaid eligibles are automatically enrolled in a fee for service program using a network of providers that contract with DHHS. Voluntarily, Medicaid clients may opt for managed care coverage through Anthem BlueCross BlueShield. S-CHIP kids are automatically enrolled in an Anthem plan with virtually the same provider network as Medicaid managed care. Most of the primary and specialty care providers in the Anthem network also participate in the Medicaid fee for service program. There are differences in the mental health network between the managed care plans and the State network.

2.7 Cost Sharing:

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

   Disenrollees – The number of children disenrolled for nonpayment of premium is tracked. In FFY 2000 about 15% of disenrollees were terminated for nonpayment and has attributed to a default of only 1.77% of total family premiums. Studies in other states indicate that many of these families acquire other coverage and simply fail to notify the State. Telephone interviews of disenrolled families are planned for early 2001 to better understand the relationship between premiums, affordability and disenrollment for nonpayment.

   Eligibles but Not Enrolled – In this category, we have two groups. Prospective families are those who have requested an enrollment kit but did not apply. Declining families are those whose children have been deemed eligible for the S-CHIP but fail to enroll (ie pay their premium and select a PCP).

Prospectives – A 1999 survey of prospective families indicates that nearly half of those who inquired but did not enroll remain uninsured. Cost is indicated as the primary reason for not enrolling. This study indicated that 76% would be eligible for free coverage so there appears to be a disconnect between what families expect to pay and what their cost-sharing would be.

Declining Families – The predominant characteristic of declining families is that they did not apply through the mail-in process. 98% of declining families are referred for enrollment through a District Office of Health and Human Services where they applied for coverage or renewed their Medicaid eligibility. Currently we do not know the percentage of new applicants versus renewing families. Of those who do not enroll but are deemed eligible, nearly 90% fail to respond to enrollment efforts which include a phone call and two letters. A 1999 survey of these families does include that premiums are a barrier for some families with 35% of families interviewed indicated they could not pay the minimum $20 premium (17% can't afford anything and 18% could afford $10). However, 43% indicate they could pay $20 or $25, and 22% indicate they could pay more.

2. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

   A study of the relationship between cost-sharing and utilization is planned for 2001.

2.8 Assessment and Monitoring of Quality of Care:

1.What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

Contracts currently provide for the submission of claims/encounter level data to evaluate access to and use of health care services.

2.What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

S-CHIP utilization is reported on a quarterly basis by the health plan. Visits per thousand and cost for categories of care are reported and compared to the commercial clientele of the health plan. As noted below, additional and more comprehensive studies are planned for 2001.

3.What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

The Quality Evaluation program for S-CHIP in New Hampshire will begin in earnest in early 2001. Through New Hampshire Healthy Kids Corporation, we have contracted with the Institute of Child Health Policy at the University of Florida to conduct studies of health care usage and family satisfaction. These studies include the analysis of claims/encounter level data and compare health care usage between Medicaid, Medicaid managed care and S-CHIP. Telephone interviews with new enrollees, established enrollees and disenrollees will be conducted to further examine access and family satisfaction.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2000 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

1. Eligibility

Criteria to discourage crowd-out by offering eligibility only to families whose children had been uninsured for six months is problematic. Many families who have sacrificed to provide high-deductible, catastrophic coverage for their families feel that Title XXI regulations are unfair to them. We encourage consideration of using Title XXI funding to provide preventive and primary medical and dental services to families who are under-insured.

Many young adults transitioning to work or continuing their education remain uninsured because Title XXI can only be extended to the age of 19.

2. Outreach

A new school lunch outreach campaign was extremely successful in reaching thousands of new families. Over 3,500 requests for applications were generated as the result of the campaign. The end of FFY 2000, however, was too early to judge the success of these campaign on enrollment.

3. Enrollment

We are particularly proud that by the end of FFY 2000, we had reached 50% of the Title XXI eligibles. Additionally, coordinated outreach precipitated by Title XXI accomplished a 37% reduction in Medicaid eligibles that were not enrolled.

4.Retention/disenrollment

Slightly less than thirty percent (30%) of Title XXI children were disenrolled. We know for certain that 65% of these children continue to be insured through Medicaid or private insurance. Less than 16% of all disenrollees were termed for nonpayment of premium, accounting for a default of only 1.77% of total premiums collected. It is important to note that studies have indicated that nonpayment of premium is not necessarily indicative of an inability to pay or that the child became uninsured. Oftentimes, these families acquire other insurance and simply fail to provide that information.

A very small number of children (less than 3% of all disenrollees) were disenrolled for failure to complete the redetermination processA three follow-up process was introduced (letter, phone call, letter) to ensure maximum retention.

5.Benefit structure-N/A

6.Cost-sharing

Approximately 20% of families who applied or redetermined their Medicaid coverage through a

District Office of Health & Human Services and were deemed eligible for Title XXI failed to enroll their children. A 1999 study indicates that premiums may be an issue for some of these families. Additionally, these families indicate the availability of safety-net services at little or no cost. Addition evaluation of these issues is planned for 2001.

It may be of interest to note that some families who are eligible for free coverage through Medicaid indicate a preference for paying premiums and enrolling in Title XXI. Clearly this is not allowed under the rules, however, families cannot understand why they would not be allowed to purchase insurance if they willing to do so.

7. Delivery systems- N/A

8.Coordination with other programs

The biggest issue regarding coordination is that Medicaid disenrollment is date specific and Title XXI is full month coverage through managed care contracts. This causes a gap in coverage for many families. Since HCFA will not allow the State to extend full month coverage only to children enrolled in Medicaid, it needs to seek alternatives solutions. The State is in the process of addressing this issue.

9. Crowd-out

Because New Hampshire requires children to be uninsured for six months unless good cause applies, there is little evidence of crowd-out. Also see eligibility.

10.Other

SECTION 4. PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.

Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).

	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
Benefit Costs	Actual	Budget	Budget
Insurance payments			
Managed care	$ 2,080,233	$4,039,805	$5,296,870
per member/per month rate X # of eligibles			
Fee for Service	$186,110	$220,056	$267,717
Total Benefit Costs	$ 2,266,343	$ 4,259,861	$ 5,564,587
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs	$ 2,266,343	$ 4,259,861	$ 5,564,587
Administration Costs			
Personnel	$62,645	$92,460	$102,120
General administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs			
Other	$192,722	$108,540	$119,880
Total Administration Costs	$251,816	$201,000	$222,000
10% Administrative Cost Ceiling	$251,816	$473,317	$618,287
Federal Share (multiplied by enhanced FMAP rate)	$1,636,803	$2,899,560	$3,761,282
State Share	$881,356	$1,561,301	$2,025,305
TOTAL PROGRAM COSTS	**$2,518,159**	**$4,460,861**	**$5,786,587**

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2000.

N/A

4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2000?

__x__ State appropriations
_____ County/local funds
_____ Employer contributions
__x__ Foundation grants
_____ Private donations (such as United Way, sponsorship)
_____ Other (specify) _____

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

The State appropriations will be increasing if the budget is approved. The Foundation contribution has been reduced.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Program Name	Healthy Kids Gold	Healthy Kids Silver
Provides presumptive eligibility for children	_____No __x__Yes, for whom and how long? Children and pregnant women-45 days	__x__No _____Yes, for whom and how long?
Provides retroactive eligibility	_____No __x__Yes, for whom and how long? 3 months	__x__No _____Yes, for whom and how long?
Makes eligibility determination	__x__State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)* _____	__x__State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)* _____
Average length of stay on program	Specify months __TBD__	Specify months: 9.67 for all kids that have been covered.
Has joint application for Medicaid and SCHIP	_____No __x__Yes	_____No __x__Yes
Has a mail-in application	_____No __x__Yes	_____No __x__Yes
Can apply for program over phone	__x__No _____Yes	__x__No _____Yes

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Can apply for program over internet	___x__No _____Yes	___x_No _____Yes
Requires face-to-face interview during initial application	__x__No _____Yes	__x__No _____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	__x___No _____Yes, specify number of months _____ What exemptions do you provide?	_____No __x__Yes, specify number of months- 6 months _____ ___ What exemptions do you provide? Good Cause for involuntary quit and certain voluntary quit reasons
Provides period of continuous coverage <u>regardless of income changes</u>	__x__No _____ Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period	__x__No _____Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period
Imposes premiums or enrollment fees	__x__No _____Yes, how much? _____ Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify) _____	_____No __x__Yes, how much? $20, or $40 depending on income. Who Can Pay? ___ Employer _x_ Family ___ Absent parent __ Private donations/sponsorship ___ Other (specify) _____
Imposes copayments or coinsurance	__x__No _____Yes	_____No ___x__Yes
Provides preprinted redetermination process	___x__ No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	___x___ No _____ Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct __ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

The initial application process involves sending in the completed application along with verification of income and deductions, proof of child(ren)'s birth age, proof of address, and picture id of at least one parent. Re-determination is a simplified mail-in process. Families must complete and sign a new application and submit new income and deduction verifications, as well as any documentation for other changes such as address change or the age verification for a new child.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2000, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child=s age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher	____% of FPL for children under age _____ _185% of FPL for children aged 1-19___ ____% of FPL for children aged _____
Medicaid SCHIP Expansion	0-300% of FPL for children aged 0-1_ ____% of FPL for children aged _____ ____% of FPL for children aged _____
State-Designed SCHIP Program	185-300% of FPL for children aged 1-19___ ____% of FPL for children aged _____ ____% of FPL for children aged _____

6.2 As of September 30, 2000, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter ANA.@*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes X No
If yes, please report rules for applicants (initial enrollment).

Table 6.2

	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings	**$90.00/worker**	**$90.00/worker**	**$90.00/worker**
Self-employment expenses	**Cost of doing**	**Business**	**same**
Alimony payments Received	**NA**	**NA**	**NA**
Paid **– court ordered**	**Full amount**	**Full amount**	**Full amount**
Child support payments Received	**NA**	**NA**	**NA**
Paid **– court ordered**	**Full amount**	**Full amount**	**Full amount**
Child care expenses	**$200/175 FT $100/87.5 PT**	**$200/175 FT $100/87.5 PT**	**$200/175 FT $100/87.5 PT**
Medical care expenses	**NA**	**NA**	**NA**
Gifts	**NA**	**NA**	**NA**
Other types of disregards/deductions (specify)	**Garnishments Income allocated to dependents**	**Garnishments Income allocated to dependents**	**Garnishments Income allocated to dependents**

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups X No ____Yes, specify countable or allowable level of asset test_____
Medicaid SCHIP Expansion program X No ____Yes, specify countable or allowable level of asset test_____
State-Designed SCHIP program X No ____Yes, specify countable or allowable level of asset test_____
Other SCHIP program_____ ____No ____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2000? ___ Yes **X** No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please comment on why the changes are planned.

On November 1st 2000, the Adminstrator of the SCHIP program in New Hampshire convened a SCHIP Summit. Representation from Healthy Kids Corporation, Robert Wood Johnson- Covering Kids grant recipients, DHHS-Division of Family Assistance, DHHS Bureau of Maternal and Child Health and other community stakeholders were present to discuss recommendations on future policy changes to improve New Hampshire's SCHIP program. From that meeting, a workplan was developed that outlined workgroups, timelines and deliverables that will lead to recommendations on policy changes, some of which will be included in a proposed state plan amendment to be submitted in 2001. The issues indicated below are those that will be examined in the next few months.

1. Family coverage

   A workgroup will evaluate whether to recommend the State apply for a 1115 waiver to allow eligibility for parents of Medicaid and Title XXI children.

2. Employer sponsored insurance buy-in

   A workgroup will evaluate whether to recommend the State apply for a 1115 waiver to allow employer purchases CHIP on behalf of employees.

3. 1115 waiver

   A workgroup will evaluate whether to apply for waivers for primary and preventive care for those who have catastrophic illness insurance and expansion to 300% for pregnant women, as well as the above issues.

4. Eligibility including presumptive and continuous eligibility

   A workgroup will bring forward recommendations on changes in the presumptive eligibility infrastructure and draft policy on curriculum, training, and evaluations. Continuous eligibility policy will be revisited to clarify and see if it can be extended to 12 months.

5. Outreach

   The CHIP outreach workgroup will be working on increasing outreach to court systems, minority and rural populations, and adolescents.

6. Enrollment/redetermination process

   Workgroups will revise current SCHIP application and bring forward recommendations on what kind of documentation should be required when applying for the program.

7. Contracting

8. Other

   A workgroup will review and revise the application based on best practices received from other state and HCFA recommendations. Good Cause waivers will also be reviewed and revised by a workgroup.